Supporting young mothers

Miriam Donaghy,
UK Council for Psychotherapy (UKCP) Registered Psychotherapist, Clinical Director of MumsAid

Sarah McGuinness & Kate Smith,
Senior Psychotherapists, YoungMumsAid

This article describes the impact of YoungMumsAid, a psychological support service for 16-18 year-old mothers and pregnant teenagers, based in the Royal Borough of Greenwich in (RBG) in South East London. We will identify common clinical themes, discuss some of the main challenges of working with this client group, and present our main outcomes. We hope to provide the reader with a sense of the complexity involved in this work which aims to make a positive difference in the lives of vulnerable young women and their babies.

Perinatal mental health problems affect an estimated 53% of new teenage mums in the UK (Reid & Meadows-Oliver, 2007). Nationally, most teenage pregnancies are unplanned and approximately half end in termination (Department for Children, Schools and Families (DCSF) (2010). In the Royal Borough of Greenwich (RBG) in 2015, there were 108 conceptions recorded in girls under 18-years of age (Public Health England (PHE) 2015) and evidence suggests that many more young women in the borough, compared to the national average, decide to carry their babies to full term.

There is a growing recognition that socio-economic disadvantage can be both a cause and consequence of teenage motherhood. Teenage parents have a 63% higher risk of living in poverty, and a higher risk of partnership breakdown and social isolation (Greenwich Joint Strategic Needs Assessment (JSNA) (2013/14). Evidence also suggests that certain groups of more vulnerable young people are more likely to become parents: including care leavers, the children of teenage parents and those living in areas of high social deprivation (Swann et al., 2003). RBG is the 19th most deprived borough in England and the 10th most deprived in London (Indices of Multiple Deprivation, 2010).

YoungMumsAid (YMA) began delivering counselling in September 2015, in two Children's Centres in Woolwich, offering up to eight teenagers a potential six months (24 sessions) of individual weekly therapy, with crèche facilities available. The project was set-up by MumsAid (a voluntary sector organisation, delivering perinatal mental health support in South East London) using an initial two-year grant from BBC Children in Need.

Since then we have worked with some of the most vulnerable young women in London. It is a tragic reality that the babies of teenage mothers have a 56% higher risk of infant death (Public Health England, 2016) and so it's not surprising that 69% of the babies we work with are deemed at risk of abuse or neglect and have social worker involvement.

The quality of relationship a baby has with their primary care-giver has long-lasting implications for their mental health and development. The South London Child Development Study (Hay et al., 2010; Hay et al., 2001) showed that the children of mothers who were anxious or distressed in the perinatal period:

- Had lower IQ at 11 and 16 years (20 points lower for boys)
- Were 12 times more likely to have a special needs statement in primary school
- Displayed an elevated risk of violence at 11 and 16 years of age
- Were more likely to have a diagnosis of depression themselves at age 16

YMA AIMS AND OBJECTIVES

Early intervention work with mothers who are struggling is fundamental to helping babies grow into children (and later, adults) who are more likely to feel happy, secure and to reach their potential. Thus the broad aim in setting up YMA was to support young mothers (16-18 year olds) during the crucial 1001 days period (from conception through to baby's first year).

We use a flexible approach based on Interpersonal Psychotherapy and Mentalisation (thinking about how we make sense of each other and ourselves), which aims to improve the mother's ability to attune to her baby, and where necessary to think about the other, often difficult, relationships in her life.

Main objectives of YoungMumsAid are defined as:

1. Improving the mental health of young mums
2. Promoting better chances of optimal development of babies, by improving the quality of bonding and attunement in mother-baby relationships
3. Reducing social isolation, strengthening support networks.

CLINICAL THEMES

As might be expected some common themes have emerged. What has perhaps been surprising has been the extremely high levels of past trauma and current domestic violence affecting many of the young women. Many have suffered abuse or neglect in childhood leaving them with unresolved trauma.

ATTACHMENT ISSUES

As a result of their early experience, many of the young mums have insecure or disorganised attachment styles, which in turn affect how they relate to their babies. In cases with Social Services involvement, a young mum often has real fears that the baby could be removed if she expresses any negative feelings about motherhood. This may impact on her willingness to be honest (at least initially) about the bond with her baby. It is important that the therapist reassures her about the context and confidentiality of the counselling, and encourages her to explore her feelings, as they are more problematic if they remain hidden or unconscious.

DIFFICULT RELATIONSHIPS

The relationship with the baby's father or with subsequent boyfriends can often be a preoccupation for a young mother, with a potentially detrimental impact on the quality of her care-giving. Many of the women we see have grown up in violent households and been with more than one violent partner. This repeated exposure increases the likelihood of tolerating violence in relationships. An important part of the therapeutic work is helping these young women to understand what a healthy relationship is; exploring the reasons why they might be attracted to abusive men, and how they might protect themselves in future (as well as helping them to understand the detrimental impact on their baby of witnessing conflict). The risk of domestic violence is increased in the perinatal period regardless of age or circumstance; however, due to the increased vulnerability of young mums and the social stigma attached to teenage pregnancy, they are less likely to seek help and have fewer resources to help them leave the relationship (Wood et al., 2011). As well as physical violence, many of the young mothers are in controlling and emotionally abusive relationships with boyfriends who may restrict their contact with friends, both in person and via social media and, in some cases, attempt to control or prevent their attending therapy.

SOCIAL ISOLATION

Social isolation can be a result of losing confidence or peer friendships after becoming mothers, or from mental health difficulties such as postnatal depression, agoraphobia or social anxieties. Reducing anxiety or depression, exploring difficulties in relationships, and providing a non-judgemental, safe space for a young mum to explore emotional difficulties, can raise self-esteem and build confidence to overcome social isolation. Support to engage in other activities is also vital as this can strengthen support networks around the family which can continue to be beneficial after the counselling intervention has ended.

TRAUMA HISTORY

60% of YMA service users have a history of child abuse or neglect and 50% have been in care or under child protection plans. They may carry years of unprocessed pain, trauma and loss within. In many cases, they have suffered from depression and anxiety in childhood, perhaps having received treatment through CAMHS or a school counsellor. Others have never had a space to talk about their experiences and consider the impact on their lives. Having a baby can often be a trigger for arousing difficult and confusing feelings about their own childhoods. Engaging in therapy can help them explore and begin to make sense of these feelings.

CHALLENGES

All the young women to-date have had multiple issues and complex histories. They often lack a model of 'good enough' parenting or any understanding of how to provide attuned attention for their babies. The therapist's first challenge is to create a safe space in which a trusting relationship can be experienced. This requires patience, a non-judgmental stance and persistence to maintain contact when sessions are missed. The significance of providing a trustworthy listening ear, and of just 'being there' cannot be over-estimated for young women who have often had very little experience of this.

The therapist gently encourages the young mum to mentalise about her baby, with comments such as, 'I wonder what he is feeling about that', or 'I wonder what she might be telling you when she does that'. The ability to mentalise is crucial to forming a secure attachment and promoting effective emotional regulation in the developing baby (Fonagy, 1989). The therapist also aims to build the young mums' confidence by highlighting and affirming any positive interactions with the baby that she reports or demonstrates.

A lack of regular attendance at therapy sessions can present a challenge to establishing a good working alliance. It is often difficult for any new mother to attend regular weekly appointments, when caring for an infant. For teenage mums, we find that their often chaotic lives can result in many missed sessions. Most have not been in work or attended school regularly, so have little experience of managing their time in order to turn up for weekly appointments. Also, in many cases their housing is temporary and insecure, meaning they may be moved several times during the counselling. Emergency housing can be outside the borough or a long way from the venue, which has a big impact on attendance. The more difficult and expensive the journey, the less likely the young mums are to come.

ROLE OF SUPERVISION

Supervision in YMA is a critical component of safe and effective practice. It is essential in ensuring a containing and reflective space for practitioners to acknowledge and process the often stressful, uncomfortable and indeed painful experiences of working with these young mothers, their babies, families and the systems around them.

Therapists need support in holding the despair when clients choose not to engage or miss sessions and a space to consider that resistance to the process is part of the young woman's adaptive response to her often traumatic past, rather than a statement of how well the therapist is doing. This can be particularly the case when there are strong counter-transference feelings of not being 'good enough'.

Supervision is also a place where therapists can be supported in holding the boundaries both with the young mums, where setting healthy boundaries from a place of compassionate understanding is part of the therapeutic work, and also with other agencies that may be involved. The safeguarding concerns that are often prevalent mean that therapists are quite frequently requested to contribute to child protection reports or meetings, which can take up a great deal of time. It can be challenging, although critical to the counselling, to preserve the therapeutic relationship when safeguarding concerns arise.

Working with teenage mothers, as with other groups where there may be multiple experiences of trauma, requires being ever mindful of the impact on the therapist, and the risk of burn-out and thus the importance of self-care.

OUR IMPACT: HOW WE MEASURE

The impact of the service is assessed in a number of ways. In the first instance, we obtain detailed information from the referrer regarding the mother's history and living situation and any child protection proceedings (CPP) or concerns. In addition to providing crucial information, this acts as a base-line for measuring any progress in these areas, for example if CPPs are 'stepped down'.

We support the client to complete a pre-service questionnaire which uses recognised clinical measures:- Edinburgh Postnatal Depression Scale and the Parental Stress Scale and which also includes:

- Questions on 'support' and 'social connections' aimed at assessing levels of isolation
- Self-report scales about the bond with their baby, and their confidence in parenting
- Demographic information including race, age, marital status, post-code, and whether they are receiving other support for their present difficulties (including medication).

The questionnaire is repeated at the mid-point and at the end of counselling and at any follow-ups.

In addition, whenever possible, therapists use a standardised 'Clinical Observations' sheet to record mother and baby interactions indicating how the mother thinks and feels about her baby and how her baby responds to her, as well as recording any pertinent comments she makes about her feelings towards her baby.

Finally, all those who receive counselling are asked to complete a satisfaction survey, rating and commenting on their experience of the service.

OUTCOMES

From the data gathered at referrals and pre-questionnaires, we know that:

- 60% of teenagers referred have a history of childhood abuse or neglect
- 57% have been in statutory care or under child protection (CP) plans
- 69% have experienced domestic violence
- 63% have a history of mental health problems requiring treatment.

At this point we are still analysing data from post-service questionnaires, but outcome data from the first year of delivery is promising with 67% of mums who attended 10 or more sessions reporting improvements in their anxiety or depression.

Therapist observation records indicate that 83% of young mums attending 10 sessions or more showed a reasonable to good improvement in bonding and attunement with their babies. For those attending at least 10 sessions, there was evidence of a reduction in their social isolation.

This data is affected by pregnant teenagers who ended therapy before or soon after their babies were born.

LEARNING FROM EXPERIENCE

Early on, it became clear that attending an assessment with an unknown therapist was daunting for many young women, so we adapted procedures to include an optional visit to their home, accompanied by a familiar professional such as the referrer. This led to an improvement in the take-up rate.

After the assessment visit, however, many women still decide not to take up the offer of counselling. Whilst in some cases this is due to the practical challenges they face, others are just not ready or able to make use of what we are offering. The importance of building professional networks has been crucial in developing the service. By working closely with potential referrers and sharing our learning with them, we hope to improve the suitability of the referrals they make (i.e. clients' readiness to engage) and thus improve our client engagement rate.

We have found that the teenage mothers need more holding between sessions than would usually be required. As a result, we now text all clients before each session as standard practice. In addition, we always attempt phone contact when sessions are missed and may deliver telephone sessions when the young mum cannot attend in person.

The changing circumstances of many of the

young women mean that there is an increased risk of 'drop-out' without warning. Again, we have realised the importance of building good working relationships with other professionals in their networks, giving us the best chance of re-establishing contact, so that we are able to assess any increase in risk for the well-being of the mother and her baby.

CONCLUSION

There is a real need for vital support services, such as YMA, to help young mothers overcome often traumatic histories lacking in experiences of adequate parenting, and cope with lives fraught with present difficulties such as homelessness, poverty, domestic abuse and perinatal mental health problems.

This work is incredibly worthwhile but it's not for the faint hearted. The therapists and the organisation need to be robust to withstand the presented trauma and sadness. Where we are able to engage and establish trust, we have found we can make a difference to both the young mother and her baby. We have the chance to break the cycle of deprivation that many of these babies will be doomed to repeat if their mothers do not receive the right support at this critical time. Some outcomes will never be measured but just imagined and anticipated when a 'good enough' experience is offered and has been made use of. These outcomes will reach far into the future.

CASE STUDY (ALL NAMES HAVE BEEN CHANGED TO ENSURE ANONYMITY)

When 17-year-old Ella was referred to YMA by her social worker, her baby, Rory, was five months old. She had requested counselling as she had been feeling low since the birth. She was living with her boyfriend and his family but was increasingly unhappy in the relationship as he had become jealous and controlling. Ella was feeling very isolated as she had lost touch with most of her friends during her pregnancy. She had very little contact with her family. Her mother had not been able to care for her due to her drug and alcohol dependence, so at the age of three, she had gone to live with her grandmother. That arrangement broke down when she was 14 so she moved in with an aunt. When she got pregnant, her aunt asked her to leave due to lack of space in the home.

Ella's history meant that she had little sense of what a stable relationship might be, although she appeared to have bonded well with her baby. After a shaky start, she engaged well with the counselling and attended regularly. She began to explore her feelings and made connections between the pain and loss in her history and her current anxiety and low mood. Her counsellor suggested strategies to help her manage her anxiety and over time, Ella reported an improvement in her mood. As her anxiety decreased, Ella felt better able to connect with her baby and her counsellor helped her to improve her capacity to attune to him by noticing what she was doing well. This also helped to increase her confidence in her mothering and thus her self-esteem. Ella often talked about how much she enjoyed caring for Rory. Her counsellor also encouraged her to attend a group at the Children's Centre where she made friends with a couple of other mums. She also reconnected with her grandmother and started taking Rory to visit her regularly.

Ella began to feel more confident and started to think about her and Rory's future. Her relationship with her boyfriend was becoming more and more volatile, so with her social worker's help, she decided to leave and moved into temporary accommodation with her baby. Although this was difficult for Ella, she now understood that it would be better for her and Rory to live alone. As the counselling came to an end, Ella reported feeling more optimistic about the future and had enrolled on a college course.

FOR FURTHER DETAILS ABOUT YOUNGMUMSAID, CONTACT:

info@mums-aid.org
www. mums-aid.org

REFERENCES

Department for Children, Schools and Families (2010) Teenage pregnancy strategy beyond 2010. London, DCSF.
Fonagy, P. (1989) On tolerating mental states: Theory of mind in borderline patients. London, Bulletin of the Anna Freud Centre.
Greenwich Joint Strategic Needs Assessment (JSNA) (2013/14) Closing the gap. Royal Borough of Greenwich, Public Health & Wellbeing.
Hay DF, Pawlby S, Sharp D., Asten, P., Mills, A. et al. (2001) Intellectual problems shown by 11-year old children whose mothers had postnatal depression. Journal of Child Psychology and Psychiatry 42(7),871-890.
Hay, D.F., Pawlby, S., Waters, C.S., Perra, O., Sharp, D. (2010) Mothers' antenatal depression and their children's antisocial outcomes. Child Development 81(1),149-165.
Indices of Multiple Deprivation (2010) Available at: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2010
Public Health England (2015) Greenwich Health Profile, 2015. Greenwich.

Public Health England (2016) A framework for supporting teenage mothers and young fathers. London, Public Health England.
Reid, V., Meadows-Oliver, M. (2007) Postpartum depression in adolescent mothers: An integrative review of the literature. Journal of Paediatric Health Care, 21,289-298.
Swann, C., Bowe, K., McCormick, G., Kosmin, M. (2003) Teenage Pregnancy & Parenthood. Evidence Briefing, London, Health Development Agency.
Wood, M., Barter, C., Berridge, D. (2011) Standing on my own two feet: Disadvantaged teenagers, intimate partner violence and coercive control. London, National Association for Prevention of Cruelty to Children.